Exhibit E

CHIEF COMPLAINT: Pulseless Apneic

POSITION PATIENT FOUND – Lying supine on ground/SCENE REPORT –

EVENTS LEADING TO –

AVPU: ☒ Alert ○ Verbal Responsive ○ Oriented ⇨ ☐ x4 ☐ Person ☐ Place ☐ Date/Time ☐ Event
○ Pain Responsive ☒ Unresponsive

AIRWAY –	BREATHING - 12-20 BPM	CIRCULATION -	DISABILITY-
7.5 ETT $ETCO_2$	BVM 15 L	CPR	NONE

PMH –	ALLERGIES -	MEDICATIONS -
UNKNOWN	UNKNOWN	Unknown

A – ALS ASSESSMENT:
PATIENT INFORMATION –

SIGNS / SYMPTOMS –

ONSET	PROVOKES	QUALITY	RADIATES	SEVERITY	TIME (HOW LONG)

HEAD-TO-TOE EVALUATION:

HEAD -	CHEST -	PELVIS -
EENT -	ABD -	UE -
NECK -	BACK -	LE -

Called to above address to assist Cleveland P.D. with an "unknow medical" Arrived to see police officers performing CPR on 30y/o male/black. ~~CPR cont's resp~~ CPD stated "He tried to run and was tased twice and stopped Breathing." CPR was taken over by EMS. Pt was placed on stretcher and moved to ambulance. Pt was placed on cardiac monitor, asystole x 3 leads. CPR was continued. Pt was intubated (7.5mm ETT). 18g @ EJ est. Pt was given meds q 3-5 per ACLS protocols. Transported to BMC w/o incident. Upon arrival pt report and care were given to receiving ER staff. Pt has unknown med hx and allergies

TIME	PULSE	RESPIRATIONS	BP	GLUCOSE	SaO2	EKG RHYTM	GCS
	Ø	Ø	Ø /	Ø	Ø	Asystole / PEA	3
			/				
			/				
			/				
			/				

SKIN	PUPILS	LUNG SOUNDS	STROKE SCALE	RTS / PTS

MED	DOSE	ROUTE	TIME	SOLUTION	SITE	CATH	RATE	AMOUNT
NS		IV			EJ	18g		
Epi 1:10,000 x 3	1mg x 3	IV						
Atropine x 3	1mg x 3	IV						
OXYGEN →	15L	BVM						

[illegible] ASSESSMENT | CONTROL BLEEDING | INTUBATION | OROPHARYNGEAL AIRWAY | SUCTION AIRWAY
[illegible] ASSESSMENT ADULT | CPR | [illegible] | RESTRAINTS - PHYSICAL | VENTILATOR

WILLIAMS JERMAINE
[redacted]80 30 M ER
LARTEVI EDWARD K 00062 07/23/10 00129191
6497608
BOLIVAR MEDICAL CENTER

50 Bolivar Medical Center

EMERGENCY PHYSICIAN RECORD
♦ Cardiopulmonary Resuscitation ♦

DATE: 7/23/10 TIME: 0433 ☐ on arrival ROOM: ________ EMS Arrival

HISTORIAN: patient spouse paramedics

__HX / __EXAM LIMITED BY:

TRANSFER FROM: ________ ☐ see transfer record

HPI Brought by EMS.

Initial complaint(s): collapsed found unresponsive
chest pain dyspnea abdominal pain back pain
Ambulated, Left TJ, no N ...

Witnessed arrest? no / yes ...

Bystander CPR? no / yes ... ER ... CPR

Down-time before ACLS: ______ minutes unknown

initial findings: by paramedics continue
mentation unresponsive | *respirations* no respirations, agonal respirations | *pulse* none, weak — SEE

rhythm asystole, vent. fibrillation, __PEA brady / tachy
HR CODE Glucose SHEET mg/dl
BP ______ D-stick glucometer ISTAT
by paramedics / in ED

pre-hospital treatment:
oxygen | CPR / thumper | epinephrine ______ mg
bag-valve-mask | defibrillated x ____ | vasopressin ______ mg
| IV access ______ | atropine ______ mg
| | amiodarone ______ mg
intubated | IV fluids ______ | sodium bicarb ______ amps
| | lidocaine ______ mg

See Code Sheet — DOA

ROS See EMS Reports Short form
CONST
recent illness ______
fever / chills ______
EYES / ENT
problems with vision ______
sore throat ______
CVS / RESP
chest pain ______
shortness of breath ______
cough ______
LNMP ______ preg post-menop

GI / GU
abdominal pain ______
problems urinating ______
MS / SKIN / LYMPH
joint pain ______
rash ______
swollen glands ______
NEURO / PSYCH
dizziness ______
fainting ______
anxiety / depression ______
☐ all systems neg except as marked

Unavailable

•CVS / RESP / NEURO components also addressed in HPI

PAST HX
cardiac disease AMI CHF A-Fib | diabetes Type I Type 2 ______
CVA / TIA deficit ______ | diet / oral / insulin ______
| hypertension ______
__old records ordered / summary: Unobtainable

Medications __none med list reviewed
aspirin coumadin clopidogrel

Allergies NKDA
see nurses note

SOCIAL HX smoker ______ drugs ______
alcohol (recent / heavy / occasional) ______ occupation ______
living situation alone family friend group care facility ______ See LPBS

FAMILY HX __negative ______

☐ Vitals Reviewed Abnmls Noted: BP ____ HR ____ RR ____ Temp ____
☐ Nursing Assessment Reviewed

INITIAL PHYSICAL EXAM See Code Sheet
See reverse for initial rhythm and interventions

GENERAL
__no evidence of trauma | ✓ unresponsive ______

RESPIRATORY
__breath sounds equal bilaterally
__lungs clear
| ✓ no spontaneous respirations ______
| __bag-valve-mask ______
| __ET tube / bag-valve ______
| __agonal respirations ______
| __decreased air movement ______
| __wheezes / rales / rhonchi ______

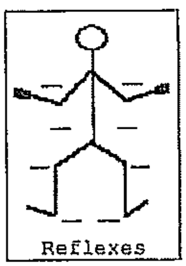
CVS
__spontaneous pulse present
| ✓ no spontaneous pulse ______
| __chest compressions ______
| *pulse w/ CPR- none poor good*
| __heart sounds absent ______
| __irregularly irregular rhythm ______
| __extrasystoles (occasional / frequent) ______
| __JVD present ______
| __murmur grade ___ /6 sys / dias ______
| __gallop (S3 / S4) ______

DOA

ABDOMEN
soft, no mass
| ✓ distention ______
| __hepatomegaly / splenomegaly ______
| __mass ______
| __guarding ______

HEAD / NECK
✓ atraumatic
__pharynx clear
| __head trauma ______ Heavy Silver
| __c-spine tenderness ______ Neck Chain
| __tracheal deviation ______ in place (see CXR!)

NEURO
__pupils reactive



| (unresponsive) / agitated / confused ______
| ✓ pupils fixed, dilated ______
| __unequal pupils ______
| *size- R ____ mm L ____ mm*
| __no motor responses ______
| __abnormal response to pain ______
| *withdraws flexion extension*
| __Babinski reflex (R / L) ______
| __reflexes absent ______

EXTREMITIES
__no signs of trauma
| __rigidity ______
| __pedal edema (R / L) ______

SKIN
__no rash
| __pallor ______ Multiple
| __cyanosis ______ abrasions
| __dependent lividity ______ SEE PHOTOS
| __decubitus ______

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INITIAL EKG MONITOR RHYTHM

asystole | wide complex | sinus rhythm
ventricular fibrillation | narrow complex | atrial fibrillation
ventricular tachycardia | tachycardia | heart block 1° 2° 3°
bradycardia
rate=_____

PROCEDURES & INTERVENTIONS

__CPR
__intubated by: *ED physician*
with #____ET tube curved / straight blade nasal / oral
Premedication:
RSI etomidate succinylcholine vecuronium
Post- intubation- Breath sounds
equal R greater than L L greater than R
Pulse Ox: *End-tidal CO2 detector:*
__central line placed *sterile technique betadine prep*
right / left internal jugular subclavian femoral
__pacemaker *external / transvenous*
__defibrillated
__foley catheter

PROGRESS

Also see CPR Flow Sheet
*Time*_____ re-examined pain reassessed improved unchanged
Notes:

LABS, EKG & XRAYS

CBC *normal except*	Chemistries *normal except*		UA *normal except*
WBC	Na	CK	WBC
Hgb	K	CKMB	RBC
Hct	CO2	Troponin	bacteria
Platelets	Gluc	PT/PTT	dip:
segs	BUN	INR	
bands	Creat		

ABGs
time:_____ RA / __LO2 pH____ pCO2____ pO2____
time:_____ RA / __LO2 pH____ pCO2____ pO2____

RHYTHM STRIP __NSR __Rate_____
EKG __ *NML Reviewed at* ____:____*(time)* Rate_____
__*NSR* __*nml intervals* __*nml axis* __*nml QRS* __*nml ST/T*
*not / changed from:*_____
CXR *Interp. By* ☐me ☐radiologist ☐visualized by me ☐Discsd w/ radiologist
__*nml / NAD* __*no infiltrates* __*nml heart size* __*nml mediastinum*

__CPR discontinued, patient pronounced dead at_____
♦AMI - *EKG / ASA / B-Blocker / Thrombolytics / PCI / transfer*
__Discussed hx, exam, results, dx & plan with Dr._____
at_____:_____*(time) response*_____
will see patient in: ED / hospital / office
__Rx given_____
__Smoking cessation counseling provided *time spent* ____*(≥ 3 mins)*
*discussed plan / triggers / challenges / risk / Rx given*_____
__Counseled patient / family regarding: __Additional history from:
lab / rad. results diagnosis need for follow-up family caretaker paramedics

CLINICAL IMPRESSION

Cardiopulmonary Resuscitation *successful unsuccessful*	Pulmonary Edema
Asystole	Pulseless Electrical Activity
Cardiac Rhythm Disturbance *V. Tach. V. Fib. A. Fib. SVT*	Respiratory Failure
♦Myocardial Infarction - *acute*	Sudden Death

CONDITION- ☐ unchanged ☐ improved ☐ stable_____
☐ critical ☐ serious ☑ deceased_____
DISPOSITION- ☑ Medical Examiner ☐ morgue ☐ transferred_____
Time_____ ☐ admitted __POA *decubitus / UTI (foley)*_____

☑ crit care 30-74 min ☐ > 74 min ☐ no crit care *(excluding separately billable procedures)*

PATIENT SAFETY ATTESTATION
☑ Concerning the care of this pt, I/we have afforded the staff an opportunity to discuss findings or concerns and I either addressed them or no issues were voiced. As available, additional documentation was reviewed (Nursing, EMS or Medication list).

PHYSICIAN ATTESTATION (use when care is provided by physician with NP).
☐ For this patient encounter, I reviewed the NP documentation, treatment plan, and medical decision making; and I had face-to-face time with this patient. All procedures were done by me except:_____

NP_____ ID#_____
MD Sig Edward Larievi, MD ID# 1428 transferred care ____:____
MD Sig_____ ID#_____ assumed care ____:____
☐ Template Complete ☐ See Addendum (Dictated / Template #_____)

Cardiopulmonary Resuscitation-50

SCHUMACHER GROUP
♦ Quality Measure Initiative